



## Missouri Pharmacy Program – Preferred Drug List



### Long Acting Narcotics

Effective 02/16/2005

Revised 01/03/2008

#### Preferred Agents

Clinical Edits May Apply

- Kadian®
- Oramorph SR®
- Duragesic®
- Morphine Sulfate ER
- Oxycontin®

#### Non-Preferred Agents

- MS Contin®
- Oxycodone ER
- Fentanyl Patch
- Avinza®
- Opana ER

<u>Approval Criteria</u>	<u>Denial Criteria</u>
Failure to achieve desired therapeutic outcomes with documented trial period for 3 or more preferred agents.	Lack of adequate trial on required preferred agents.
Documented ADE/ADR to preferred agents.	Therapy will be denied if no approval criteria are met.
Documented compliance on current therapy regimen.	Drug Prior Authorization Hotline: (800) 392-8030.
See page two for additional criteria	

## Approval Criteria

Approval Diagnoses				
Condition	Submitted ICD-9 Diagnoses	Inferred Drugs	Date Range	Client Approval (Initials)
Cancer	140 - 208	NA	2 years	
	NA	Antineoplastics	12 months	
Opioid Tolerance*	NA	Opioids	> 7 days supply in the last 30 days	
Chronic nonmalignant pain (CNMP):	282-355 710-733.7	NA	1 year	
	NA	Non-opioid analgesics	90 days	

\*Inferred diagnosis of opioid tolerance required only for Oxycontin 80mg and 160mg tablets and Duragesic doses greater than 25mcg/hr.

- Oxycontin/Duragesic Clinical Criteria
  - Therapy for pediatric patients under 19 years of age subject to Clinical Consultant review.
  - Documented appropriate diagnosis - see approval diagnoses box
  - Therapy dosed under dose optimization limitations
- Failure to achieve desired therapeutic outcomes with trial on 3 or more preferred agents
  - Documented trial period for preferred agents
  - Documented ADE/ADR to preferred agents
- Documented compliance on current therapy regimen